KANSAS DEPARTMENT FOR AGING & DISABILITY SERVICES
Health Occupations Credentialing
APPLICATION FOR
SPEECH-LANGUAGE PATHOLOGY AND/OR AUDIOLOGY LICENSE

TYPE OF LICENSE

Circle type of license.

Temporary: $65.00
Full: $135.00
Reciprocal: $135.00

Speech-Language Pathology
Audiology

See attached fee schedule. Fees are pro-rated for partial year license. Enclose non-refundable fee payable to "KDADS". Fees can be charged to Visa or Master Card. Charge authorization form must be completed and returned to utilize this option.

APPLICANT INFORMATION

Name: _____
Last First MI Other

Address: _____

Phone: Work(____) _____ Home (___)_____ Birthdate: _____/_____/_____ SSN _____

(Attach a copy of your Social Security Card or document bearing your name and Social Security Number.)

EDUCATION—List

	College/University	Degree	Date Conferred
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

●Transcripts showing award of a Master's Degree in Speech-Language Pathology and/or Audiology must be sent by the college/university directly to Health Occupations Credentialing.
●The college/university must be regionally accredited by the United States Department of Education and with American Speech-Language Hearing Association approved program. If you hold a degree or completed course work from a non-accredited institution, you must complete Supplement A. (request from the department)
●Degrees or transcripts received from schools outside the United States or its territories must be translated and/or evaluated by a validating agency.

CLINICAL PRACTICUM

TEMPORARY LICENSE

Single License: Submit documentation on institutional letterhead signed by the college/university program or clinical director verifying completion of 400 clinical practicum hours, of which at least 325 hours were completed at graduate level.

Dual License: Submit documentation on institutional letterhead signed by the college/university program or clinical director verifying at least 325 graduate clinical practicum hours in each discipline and that the program is consistent with the standards of the state universities of Kansas, or approved by the Secretary.

FULL/RECIPROCAL LICENSE

Applicants for a full/reciprocal license must submit either university documentation of clinical practicum OR certificate of clinical competence.

SUPERVISED POSTGRADUATED PROFESSIONAL EXPERIENCE

TEMPORARY LICENSE

Have you completed a supervised postgraduate professional experience of at least 9 months full-time, or its equivalent? **Y/N**

If NO, complete and return the "Supervised Postgraduate Professional Experience Plan."
If YES, complete and return the "Supervised Postgraduate Professional Experience Documentation."

FULL/RECIPROCAL LICENSE

Applicants requesting a full/reciprocal license may submit either documentation of completing the experience signed by the supervisor OR a Certificate of Clinical Competence.

EXAMINATION

TEMPORARY LICENSE

Have you taken and passed the NTE Specialty Area Test in Speech-Language Pathology or Audiology? **Y/N**

Request that ETS send the results to the department. The department's score recipient code is 7272.

FULL/RECIPROCAL LICENSE

Applicants for a full/reciprocal license may submit verification of passing score OR Certificate of Clinical Competence.

LICENSE IN ANOTHER STATE

List all states in which you have ever held a speech-language pathology and/or audiology license:

State: _____ State: _____ State: _____

State: _____ State: _____ State: _____

For each state, complete Part I of the "Verifications of License" form, request that the state board complete Part II and return to KDADS.

DISCIPLINARY ACTION

●This information is required under Kansas law: K.S.A. 65-6506(d)(1) and K.S.A. 65-6508(g)

Has any license, certification, or registration issued by Kansas or another state or entity been denied, refused for renewal, suspended, revoked or subjected to any other disciplinary action? Y/N

If YES, please explain:

_____

_____

_____

Have you ever been convicted of a crime by any court (including Kansas), or any federal court of the United States? Y/N

If YES, please indicate:

Date of conviction: _____

City, County and State of conviction: _____

Crime of which convicted: _____

I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the board to verify any information provided in this application and attachments. I understand that the application fee is non-refundable should I not meet licensure qualifications.

_____ _____

Signature of Applicant Date

☞ **PLEASE NOTE: YOUR SIGNATURE MUST BE NOTARIZED**

SUBSCRIBED AND SWORN TO before me, the undersigned authority, on this _____ day of _____, 201_____

_____

(Notary Public Signature)

My appointment expires: _____

Submit applications, supporting documents and fee to:

Health Occupations Credentialing
612 S Kansas
Topeka, KS 66603-3404